The Path to Transformation – 1115 Medicaid Waiver Recommendation and Comments

The Illinois Alcoholism and Drug Dependence Association (IADDA) appreciates the opportunity to provide recommendations and comments that will enhance the 1115 Medicaid waiver application. "Substance abuse is clearly among the most costly health problems in the United States" (*National Institutes of Health [NIH], 2000).* Following are services that will strengthen Illinois' ability to provide a full continuum of care to persons who are at risk of or who have substance use disorders (SUD). That continuum will support the vision of prevention, screening and early intervention, treatment, and recovery, integrated with primary health care.

Case Management: While integral to the support of patient engagement and recovery, case management for substance use disorders is not a covered service within Illinois' Medicaid Plan. This undermines the goals of federal Mental Health Parity and Addiction Equity Act (MHPAEA) within the behavioral health system, as well as parity within the new healthcare environment envisioned by the ACA. The value of case management has been widely documented and researched, as recognized through its inclusion in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices. In addition, SAMHSA has authored Treatment Improvement Protocol (TIP) #27 dedicated to case management as a best practice guideline. We urge the following:

- IADDA strongly recommends the addition of SUD case management within the Illinois Medicaid Plan for reasons of parity and treatment efficacy.

Safe and Drug Free Housing: *"Housing is to recovery as water is to swimming" (Dr. H. Westley Clark, Director, SAMHSA's Center for Substance Abuse Treatment (CSAT).* Under the rubric of safe and drug free housing, a range of services can be found that include recovery homes and residential extended care, as well as the domiciliary portion of the American Society of Addiction Services (ASAM) Level 3.5 residential care. Recovery homes may be a form of supportive housing that provides structure, access to community based resources, and is geared to those in recovery from SUD's. Recovery homes provide a bridge between treatment and full integration into the community, and have been well researched (*Polcin, D.L., Dorcha, R.A., Bond J. and Galloway, G. [2010]).* SAMHSA provides further support for the recovery home concept through its TIP #30. The draft

waiver concept paper speaks to the necessity of providing "*the right care, in the right setting, at the right time…. [to ensure] that supportive services exist in the home and community…"* While this statement is in the context of **Pathway #1,** and references the Olmstead decrees, it is also relevant to persons with SUD's and forms a foundation for long term recovery that cannot be achieved without a stable drug free housing environment.

A second level of housing is residential extended care. It provides the above structure and resources in addition to provision of a number of outpatient treatment hours each week. Often called a "halfway" house, residential extended care is yet another bridge to wellness. It contains the active clinical component of treatment, coupled with a safe and drug free housing environment. The clinical component further stabilizes the path to recovery as patients seek employment, or establish a support network.

The most complex level of care that can be partially construed as "housing" is ASAM Level 3.5 residential treatment. Residential inpatient treatment encompasses intensive individual and group clinical services while the patient resides in a licensed health care facility. A 2004 NIH study conducted in Illinois demonstrated that ASAM Level 3.5 residential treatment, while initially costing more than intensive outpatient or outpatient treatment, had the greatest return on investment and produced the most long-term savings (*Dennis, M. and Scott, L., NIH – NIDA Grant No. R37 DA011323 [2004]).* However, current Medicaid policy does not allow billing for the domiciliary portion of a patient's stay. The billings are divided between Medicaid and General Revenue Funding (GRF), and the domiciliary portion is charged to GRF. A significant disparity occurs when comparing this level of care with hospital stays. Patients <u>do not</u> experience separate billing for their "room and board" while in an inpatient hospital facility. Hospitals have successfully negotiated inclusion of their room and board costs within their rates, but to date, licensed providers of SUD treatment have not been allowed to do so. This again flies in the face of the new parity mandate, and reflects a greater burden on General Revenue Funding.

The Illinois Alcoholism and Drug Dependence Association requests the following related to housing:

- Inclusion of Recovery Home services in the 1115 waiver application.
- Inclusion of Residential Extended Care services in the 1115 waiver application.
- Inclusion of domiciliary costs within a Medicaid residential rate for substance abuse treatment.

Institutions for Mental Diseases (IMD) Exclusion: As Illinois moves to implement the ACA, the IMD exclusion looms as a significant limitation for persons requiring Level III.5 residential care for SUD's. This exclusion of a clinically defined level of care will seriously impact recovery, have a negative impact on other systems, (i.e. criminal justice, child welfare, hospital emergency departments), and will escalate costs in the longer term when persons are denied this critical level of care. Access to residential treatment will be severely limited, as many inpatient SUD treatment facilities cannot meet the IMD criteria of having fewer than 16 beds, or would have to significantly reduce the number of beds to meet the criteria. This diminished access to care will erode one of the primary goals of the ACA - expansion of access. Persons may be forced to seek treatment in a much higher cost hospital setting. In addition, parity issues are again raised. There is a glaring inequity, since for no other conditions, are Medicaid services excluded in certain medical institutions. IADDA recommends the following:

- Seek a waiver of the IMD exclusion within the Pathway to Transformation request.

Addiction Prevention and Interventions: Prevention and wellness have a much greater role in the ACA, and Illinois' system transformation must expand and grow that premise. The waiver concept paper acknowledges wellness strategies in Section 3A of the paper and proposes a category of "Designated State Health Programs" within the Financing/Budget Neutrality section. Addiction prevention is a prime candidate to be deemed a Designated State Health Program. "It has been well established that a delay in onset [of drug or alcohol use] reduces subsequent [addiction/dependence] problems later in life, (*Grant & Dawson, 1997; Lynskey et al., 2003).* The reinvestment of savings will greatly benefit the community based services provided through SUD prevention, a program that has experienced a shocking **87% decline in state funding in** the past seven years. This decline is counter to **research that has identified a savings of $18 dollars for every $1 dollar spent on SUD prevention**, (*Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, SAMHSA Center for Substance Abuse Prevention).* Reinvestment in the SUD Prevention system will provide significant returns. We laud the inclusion of SUD prevention in the draft concept paper and would like to include two other services currently funded by GRF. They are **Community Intervention and Early Intervention.** These service levels are

currently funded by GRF dollars, are integral to the continuum of care, and play a significant role in community-based health education and promotion services. IADDA requests:

- Inclusion of addiction prevention reinvestment as a part of the Medicaid waiver request.
- Inclusion of Community Intervention and Early Intervention, as a part of the continuum of care to be included in the Medicaid waiver request.

Workforce Training/Loan Repayment: As cited in the concept paper, the expansion of healthcare to additional populations and the provision of additional services will compound the current dearth of personnel in the SUD workforce. The avenue of loan repayment and the ability to remain current through ongoing training would appeal greatly to persons contemplating entry into the SUD field workforce or those SUD professionals already practicing. In addition to the clinical aspect of services, there is a body of research and a high level of interest on the part of the Centers for Medicare and Medicaid Services (CMS) to augment some workforce activities through use of peer mentors/recovery coaches. (*CMS Guidance on Peer Support Services, August 15, 2007, SMDL#07-011).* Further, the Illinois Department of Healthcare & Family Services' (DHFS) September 2013 *Report on the Detoxification Services Planning Process and Resulting Recommendations* recommends a recovery coach model. Once trained and certified appropriately, recovery coaches can help meet the demand for services related to patient engagement, recovery management, and the critical linkage needed to support long term recovery. IADDA requests the following action be taken:

- Inclusion of Medicaid reimbursement for SUD peer support services in the 1115 waiver request.
- Inclusion of current and future SUD personnel within the construct of Loan Repayment (4B), and the Other Workforce Training (4C).

Detoxification: Within the most recent ASAM Criteria (Third Edition, 2013), there are multiple levels of detoxification care. These include Level 1 Ambulatory Withdrawal Management (WM) without extended on-site monitoring, Level 2 Ambulatory WM with extended on-site monitoring, and Level 3.2, Clinically Managed Residential WM. None are currently in Illinois' Medicaid Plan. These are clinically significant levels of care, but should not be used in lieu of higher levels of detoxification if medically necessary. IADDA requests the following:

- Inclusion of ASAM Level 1 WM, Level 2 WM and Level 3.2 in order to provide the least restrictive environment while meeting clinical need.

Service Integration: One of the tenets of healthcare reform, as well as the 1115 waiver concept paper, is integration of primary care with behavioral health. However, there is a planning process that needs to occur to define the steps to integration and how they translate into practice in the SUD field. In order to achieve full integration, a thoughtful, comprehensive, inclusive process needs to guide development of full service models that support all elements of the continuum of care. There is a need for infrastructure planning to encompass all factions within the defined models, including physical plant requirements, clinical requirements, staffing requirements, treatment protocols, evidence-based practices and procedures, and the critical interface with primary care. IADDA urges Governor Quinn, HMA and DHFS to consider the needs of Illinois' SUD community-based provider network in addressing model program elements to integrate primary care and behavioral health.

Commentary: While IADDA appreciates the opportunity to prepare recommendations concerning the 1115 Medicaid waiver, we must also point out some concerns. References to SUD prevention and treatment are minimal throughout the document. Much of the behavioral health discussion relates only to mental health. We would like to emphasize the following:

- Addiction and mental illness are both chronic diseases of the brain.
- Both populations experience high rates of trauma and abuse, and both are stigmatized.
- Both populations have criminal justice and public safety implications and consequences; SUD has great potential for cost savings in criminal justice, if appropriately treated.
- Individual patients have either a primary diagnosis of addiction or mental illness and many may have a co-occurring disorder, but people with SUD seldom have a severe and persistent mental illness.
- The type, size and scope of services used to prevent and treat each illness vary significantly.

Lastly, we would like to emphasize that not only has the mental health system suffered funding loss, but SUD prevention has lost **87%** of its funding in past seven years, and the treatment system has lost **41%** of its funding in the same time period.